

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155661		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/12/2011	
NAME OF PROVIDER OR SUPPLIER OWEN VALLEY HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 920 W HWY 46 SPENCER, IN47460			
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F0000	<p>This visit was for the Investigation of Complaint IN00088970.</p> <p>Complaint IN00088970: Substantiated, federal/state deficiencies related to the allegations are cited at F226, 282, 309, and 329.</p> <p>Survey dates: April 8, 11, & 12.</p> <p>Facility number: 010892 Provider Number: 155661 AIM number: 200229560</p> <p>Survey Team: Diane Dierks, RN</p> <p>Census Bed Type: SNF/NF: 103 SNF: 4 Total: 107</p> <p>Census Payor Type: Medicare: 7 Medicaid: 80 Private: 20 Total: 107</p> <p>Sample: 3</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC</p>			F0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during a Complaint Survey review concluding on April 12, 2011. Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before May 12, 2011.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0226 SS=D	<p>16.2.</p> <p>Quality review completed on April 25, 2011 by Bev Faulkner, RN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review the facility failed to implement policies and procedures for reporting significant injuries, as evidenced by numerous wounds and abrasions acquired in the facility without reporting those injuries for 1 of 3 residents reviewed for following facility policy (Resident C)</p> <p>Findings included:</p> <p>A review of Resident's clinical record was conducted on 4/08/11 at 4:00 pm. The record indicated the resident had the following diagnoses but not limited to Anxiety, Dementia with behavioral disturbances, Syncope, and hypertension. He admitted to the facility on 4/01/11 at 4:30 pm. Resident C was admitted to the hospital as Intensive Care Unit on</p>			F0226	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident readmitted to Acute Care Psychiatric Hospital. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice therefore through systemic changes stated below will ensure the campus will provide a safe environment. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Mandatory Inservice for all facility staff on Abuse and Neglect Procedural Guidelines (attachment 1), and Reportable Event Procedure Guidelines (attachment 2). Inservices will occur May 5, May 6, and May 9, 2011. How the corrective measures will be monitored to ensure the alleged deficient</p>		05/12/2011

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	<p>3/18/11, ttihen was placed on ttihe psychiattiric unjttand when ready ffor release, ttiransffierred ttio ttihe ffiacilittiy ffor ttiherapy ttio increase his sttirengttih The ffiacilittiySkin Impairmenttti Assessmenttti, dattied4/02/11, indicattied ttihe ffiollowing abrasions occurredbutti were notti presenttti on his admission on 4/01/11 att4:30 pm: " L outtier kneed7.5 cm lengttih and4.0 cm widthtihand ttiender L outtier lower leg10.0 cm lengttih and3.5 cm widthtihand ttiender" (admitted scattiered scrattiches anttierior L Jeg abrasion L knee-4.0 cm lengttih with4.0 cm widthtih) The ffiacilittiySkin Impairmenttti Assessmenttti, dattied4/4/11, indicattied ttihe ffiollowing skin issues occurredbutti were notti presenttti upon admissionR hip bruise (3.0 cm lengttih and3.0 cm widthtih) and bilattieral hip rash(general lengttih) ittiching and red' A ffiacilittiy policattied1/1/11, ttittiled "Reportttiable Eventtti Procedural Guideline,"was provided by ttihe Divisional Clinical Supporttti Registtiered Nurse (DCS-RN) on 4/12/11. The Guidelines ffor a reportttiable eventtti indicattiedbutti was notti limittied ttio</p>				<p>practice does not recur:Educate all facility staff on Abuse and Neglect Procedural Guidelines and Reportable Event Procedure Guidelines during the inservices on May 5, May 6, and May 9, 2011. New staff will receive education during orientation and twice yearly.A written pre-test and post-test (attachment 3) will be administered on Abuse and Neglect and Reportable Events upon new hire orientation and twice yearly.Human Resource Manager will audit all new hire files for completion of Abuse and Neglect and Reportable Event Procedure Guidelines with a pre-test and post-test. ADHS/Designee will track all staff attending mandatory inservices and report results to the QA Committe for review.</p>		

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	<p>"...Purpose: To provide guidelines ttio ensure reporttiable occurrences are recorded and monittioered in accordance wittih sttiattie and ffederal guidelines...Occurrences ttio be reportttied include:...Significantti injuri(Conttiactti your Divisional Nurse ttio discuss injury on an individual basis)...or requires hospittializattion"</p> <p>The residentti was readmittied ttio ttihe hospittial on 4/05/11. The hospittial provided a listti offi ttihe residentti's abrasions, scabs, bruises, and all areas locattied on ttihe pattienttis body ttihatti were new and/or larger since 4/01/11. The hospittial documenttiattion nottied abrasions, ranging ffrim 1 cm in diamettier ttio 20 cm in diamettier and 1 cm in widttih. They include ttihe ffiollowinggutti notti all inclusive:</p> <ol style="list-style-type: none"> 1. L lattiera(outtside porttion) knee (20 cm lengttih and 5 cm widttih), L lattieral knee (20 cm lengttih and 8 cm widttih), L lattieral knee/leg (17 cm lengttih and 8 cm widttih), L medial knee (10 cm diamettier), L medial knee (7 cm diamettier). 2. R lattieral hip 10 cm diamettier abrasion and L lattieral hip 11 cm diamettier abrasion. 						

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	<p>3. R lateral calf below knee cap 4 cm diameter; R medial knee cap (6 cm diameter); on R knee cap (5 cm diameter); R lateral knee cap 6 cm diameter; R medial below knee cap (3 cm diameter)</p> <p>Hospital readmission nursing notes indicated the following: on 4/05/11 at 10:01 pm, "Pt describes pain as 'throbbing but not too bad' 4/6/11 at 9:00 am, 'Wounds are still red and weepy, cleansed with Caraklen and bacitracin ointment applied per orders...', 4/6/11 at 4:25 pm, 'Pt presents with multiple abrasions, open easily with the slightest off pressure or touch.' 4/07/11 at 2:10 am, 'all pressure points monitored, dog roll utilized with all peri care...bacitracin applied to all affected areas off skin breakdown', 4/07/11 at 9:30 am, 'all wounds cleansed...ointment applied to all wounds but knees...left knee..still red edematous with serousanguinous drainage...pt's pants were sticking to top off the wound family asked to bring in shorts so knees would not be irritated by pants.'</p>						

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	<p>As a followup, 4/11/11 at 10:35 a.m, the verbal interview facility provided a written summary that was prepared by the DHS Director of Health Services. The written summary indicated that the extent of the resident's acquired skin injuries had not been reported to the required regulatory agencies as required by the Indiana State Department of Health reporting guidelines. The DHS did not see the injuries need to be reported so no investigation was needed either. No information was located in the clinical record or provided which would have indicated speaking to the Divisional Nurse to discuss the resident's extensive skin injuries.</p> <p>This federal tag is related to the complaint number 100088970.</p> <p>3.1-28(a)</p>						

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F0282 SS=D	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review the facility staff failed to transcribe admission orders for Ativan (an antianxiety) or Motrin (for pain and inflammation) medication for 1 resident in 3 reviewed for behaviors which resulted in untimely-untreated, agitated behavior and numerous skin wounds and abrasions. (Resident #C)</p> <p>Findings include:</p> <p>A review of Resident's clinical record was conducted on 4/08/11 at 4:00 pm. He admitted to the facility from an inpatient psychiatric hospital on 4/01/11 at 4:30 pm. The record indicated the resident had the following diagnoses: anxiety, Dementia with behavioral disturbances, Syncope, and hypertension.</p> <p>The facility received a copy of the hospital's medication orders dated 4/30/11 which was sent to the facility on the day of admission for Resident A.</p>			F0282	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident re-admitted to Acute Care Psychiatric Hospital. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice therefore through systemic changes stated below, will ensure the campus will provide a safe environment. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: New practice (attachment 4) says that admitting nurse will verify orders with the M.D. and transcribe admission orders to the Medication Administration Record (MAR) and the Treatment Administration Record (TAR). The nursing Unit Manager/Designee will then confirm accuracy of transcription to MAR/TAR within four hours of admission. Admission Nurse and Nursing Unit Manager/Designee will sign off on all admission orders. All licensed nursing staff will be inserviced on Admission Orders Verification Practice.</p>		05/12/2011

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	<p>(4/1/11 at 4:30 pm). The individual medications had not been marked by the hospital which would indicate the medication was to be continued or discontinued on transfer to the ECF (extended care facility). The nurse had contacted the physician to reconcile the orders, before admission and had documented a notation next to each medication on the document. The nurse documented the following information but it is not all inclusive: ...Ativan (anxiety medication) 0.5 mg po q4h prn was noted to be "dup" (duplicate order) and not transcribed as ordered and Motrin 800 mg po q6h prn for pain and inflammation was discontinued.</p> <p>The Physician discharge orders, for Resident A were dated as 4/01/11 at 1:44 pm and faxed to the facility on 4/19/11 at 1:44 pm. The orders indicated the resident had admitted to the hospital on 3/18/11 with a diagnosis of Syncope/fainting or loss of consciousness. The medication orders were noted to be current medications as of 4/01/11 at 1:44 pm. The orders were as follows but are not</p>				<p>(attachment 4) on May 5, May 6, and May 9, 2011. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Medical Records/Designee will audit all admission orders (attachment 5) to ensure accuracy of transcription to Medication Administration Record and Treatment Administration Record. All new admissions will be audited for 90 days with results reviewed in monthly QA meetings for 3 months.</p>		

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	<p>all inclusive: "... Attivan0.5 mg po q4h prn ttio be continuedAttivan0.5 mg po QD routine ttio be continuedMottirin 800 mg po q6H prn." The MAR (medicattion administtirattion recojndicattied ttihe residenttti was also sttiartttied on Zyprexa Zydis 10 mg atti bedttim on 3/28/11.</p> <p>A review offi ttihe ffiacility MAR ffior Residenttti Cindicattied ttihe ttiranscribed orders were dattied ffi 4/01/11 ttihrough 4/30/11. There was no Attivan0.5mg po q4h, prn documentttied on ttihe MAR or ttihe order ffior Mottir800 mg po q6h, prn(ffior pain and inffiammattio)had notti been ttiranscribed on ttio ttihe MAR. An addittional MAR was provided wittih a sttiarttti dattie offi 4/03/11 ttihrough4/30/11, which indicattied an order was ttiranscribed as Attivan0.5mg 1 po q4h routine and no Mottirin 800mg had been added ttio ttihe MAR. A review offi ttihe physici'an ttielephone orders indicattied an order had been received, dattied4/03/11 att11:50 am, ffior Attiva0.5 mg 1 po q4h routine</p> <p>The ffiacility ffiorChange in Condition Form, dattied4/2/11 att7:20 am, "res</p>						

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	<p>insistting upon being allowed ttio lie on ffloor. Notti easily redirecttiedhottied abrasions ttio bila(ttiattier)lknees ffirm being on fffloor early in AM..." 4/3/11atti 11:50 am, indicattied "Family (atti bedside. Sttiattie res(esident)was receiving Attivan Q (h) routtine while atti (name) Unitti.sttiattie res seems ttio be worse since med was decreased Requestting med be a Q4h...Physician order/response ttio communicattionAttivan qh routtine Alz (Alzheimer's (wittih)behaviors..."</p> <p>Nursing notties indicattied4/1/11 att4:30 pm, "Res arrived via EMS on gurney wittih ffamily presenttts 4/2/11 att4:00 am, "Res has been (up) ett(down) mostti offi...1:1 needed.res atttemptting ttio getti up (wittihoutttsistti"</p> <p>Inttierviews offi ffiacilittiy sttia4/12/11 indicattied ttihe ffiollowingttti notti all inclusive: Nurse #1 worked on ttihe nightti offi admission, 4/1/11atti midnighttti unttil nextti morning attiam. She indicattied "...He ended getting area ffirom crawling around on fffloor..wanttied ttio sttiay on ffloor...area on knee...happened ffirom</p>						

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	<p>crawling on floor within 10 minutes red color...nothing ever like I had seen before like red jello color." "C.N.A. #2 indicated she worked on 4/2/11 and the resident...was a hand full. couldn't keep...in bed..family requested he had med to calm him down.he'd have his clothes off in minutes after we put them back on..would wiggle on mattress.he did get rug burns from being on carpet. He done (sic) it himself...The Unit Manager indicated she was at the facility on 4/3/11 (the weekend) and the resident "...was adamant.wanted on floor was disrobing at least 8 times..he crawl (sic), scoot around lay on back and push across the floor with his feet bent on back, lay on stomach and pull himself across carpet."</p> <p>Hospital nursing noted 4/6/11 at 2:00 pm, "...met with patient's wife. to discuss wounds...wife reported on 4/2/11...was informed patient had gone to his knee's..the prior night 4/1/11)...saw the abrasion on left knee...was very restless.orderly...in attendance with patient moving from bed to chair several times on</p>						

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	<p>reporttied.pattienttion...ffloor during evening. Wiffie also described requesttting his medicattion affier discovering ttihere was a delay in him receiving itti.requestttied itti ttiwison also requestttied ttihe medicattion during evening...."</p> <p>This ffiederal ttiag is relattied ttio complaintti number IN00088970.</p> <p>3.1-35(g)(2)</p>						
F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.						

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	<p>Based on observation, interview, and record review, the facility failed to protect a resident from self-injurious behaviors and seek an acute care facility to prevent further injury to his skin. For resident, reviewed for provision of care, in that the resident was placed on his floor where he constantly moved about by scooting, crawling, rubbing, and snake-like movements over the carpet with bare skin from disrobing and voiced complaints of itching. This constant moving resulted in skin concerns including abrasions, rug burns, rashes, and other skin damage which required treatment by the wound team at the hospital. Resident:</p> <p>Findings include:</p> <p>A review of Resident's clinical record was conducted on 4/08/11 at 4:00 pm. He admitted to the facility from an inpatient psychiatric hospital on 4/01/11 at 4:30 pm. The record indicated the resident had the following diagnoses: anxiety, Dementia with</p>			F0309	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident re-admitted to Acute Psychiatric Hospital to prevent further injury. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective action taken: All residents with behavior concerns and/or skin issues have the potential to be affected by the same alleged deficient practice therefore through systemic changes stated below, will ensure the campus will provide a safe environment. Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur: Customer Service Representative will perform an on-site pre-admission assessment on all resident referrals with wound issues and/or behavior concerns. All Licensed Nursing Staff will be in-service on May 5, May 6, and May 9, 2011 on Change of Condition Guidelines (attachment 6) and Change of Condition Form (attachment 7). Wound Care Nurse/Designee, in conjunction with Admitting Nurse, will do skin assessments on all admissions and with the Discharge Nurse on all discharges, and will document assessment findings in residents medical record for 90 days. Thereafter the Admitting Nurse</p>		05/12/2011

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	<p>behavioral disturbancesSyncope, and hyperttension</p> <p>The nottieswritten by ADHS(Assistiantti Directtior offi Healttth Serv)were reviewed. On 4/1/11 attt 4 pm, ttthe notties indicattied speaking wittth ttthe offi hospittial unittt relattied ttto Residentt C histtory Itti was nottied ttthe nurse ffrom ttthe hospittial indicattied he had behavioral issues...was resttlessness notti aggression...Dr. (name) wanttied (residentt)..tttio.rehab so can getti sttironger so he can pace...no behaviors since 3/23/11..." On 4/1/11 attt 5 pm, ttthe notties indicattied"...asked...iffi...(name)would acceptti residentt back.iffi were unable ttto meetti his needs." The nottiesdattied 4/1/11 attt 6 pm, indicattied"...residentt resttlessconsttianttly moving around in bed scratttching attt ffiorehead and bilatttial lower legs sttiatttnglid you bittie mffie wiffie redirecttting residentt ttthattt no one bittt him butti.keeps on picking..."</p> <p>C.N.A. #2 was inttierviewed on4/12/11 attt 2:22 pm. She indicattied"...work on weekend on Sattturdattt4/02 ...he was</p>				<p>adDischarge Nurse will contnue to assess and document assessments on all admissions and discharges (attachment 8).How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:Medical Records/Designee will audit residents admission chart within 72 hours of admission, to ensure the skin assessment is completed. Medical Records/Designee will audit resident discharge chart within 72 hours to ensure skin assessment completion. Results of Medical Records audit will be forwarded to the QA Committee monthly for review and further recommendations.</p>		

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	<p>handffiu. Couldrtti keep in bed.keptti ttiaking clottihs offimpossible ttio keep him in bed on mattis.Tried ttio give ttihe bestti care we could..ffamily ttihere and agreed ffor him ttio be on ffiocffamily requestttied he had med ttio calm him some...didn'tti sleep sttillHe'd have his clottihs offi in 5ninutties affier ttihey were putti on him.would wiggle on matti.did getti rug burns ffirom being on carpetti done [sic] itti ttio himselffi</p> <p>An inttierviewwon 4/12/11 att3:25 pm wittih C.N.A. #1, indicattied she had worked ffirom 6 am ttio 6 pm on 4/01/11, ttihe day offi Residentti 3 admission. They indicattied" ...impossible ttio getti him ttio sitttill a serious case offi ttihe wigglehe would snake, slittihsomettimes on matti somettimes on rug Always scratttching and picking on skin... " C.N.A. #3, inttierviewedon 4/12/11 att3:06 pm, indicattied she had worked nighttis on Satttiurday(4/2) and Sunday (4/3). "...he was on ttihe fffloor wittih docttiorder. Keptti sttirippingwould slide on ttihe carpetti(wittihoutti) clottihs on Sunday nightti..ffound done'sie' wittih a</p>						

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	<p>sweattier.borrowed itti and putti itti.otti was on sttill slid around on fffloor butti his skin was covered...also...ttiook offi elbow and knee pads...had rug burns on legs, arm, area, chestti and ffiooreheadthinks ttihey were rug burns.didn'tti crawl ...whole body would slide across carpetti.had putti 1matti on fffloor...he..ffioled itti and pushed itti outti offi ttihe way.over ttihe weekend. "</p> <p>Nurse #2, inttierviewed on4/12/11 att2:44 pm, indicattied" ...he couldn'tti walk ...keptti ttirying ttio getti up his alarms keptti going offi att6:00 am...conttirolled fffiall.helped him ttio ttihe fffioarnded getting rug burn fffrom crawling around on fffloor..wanttied ttio sttiayarea on knee was red fffrom fffialhappened on...ffloor wittihin 10 minutties.wanttied ttio getti him up and notti letti him crawl look whatti happened...did 1:1...restti offi shiffiid incidentti reportti on skin"</p> <p>An Incidentti Reporttiattied4/02/11 atti 02:45 am, was provided by ttihe fffacilittity on 4/12/11. The reportti indicattiedd ...wittinessed.res (residentti)..up walking</p>						

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	<p>around bed attempting to turn off alarm...wristed assistive device declined to get up off floor abrasion to (left) knee and L outstretched leg...assisted himself in walking injury-witnessed... "</p> <p>The nursing staff dated 4/04/11 at 3:00 pm, indicated Wiffie notified resident remains restless.non-redirectionable crawling on floor removing clotting.rolling up mat on floor..informed staff concerns because resident.repeatedly removing clotting.scooting across carpet causing abrasions throughout. Currently has abrasions on chest, stomach, back, buttocks in addition to abrasions he came with.also scratching at.picking...abrasions...scabs...staphylococcus e 2 mattresses[sic], three mats numerous blankets on floor to keep resident from causing further injury to self "...resident would roll up the mattress them and then roll on the floor 4/4/11 at 6 pm...res has multiple rash areas that res noted to be picking at skin tearing in several places. "</p>						

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	<p>The nursing notitiesdattied4/5/11 att10:30 am, indicattied ttihe acceptting hospittial had contiacttied ttihe ffiacilittiy and sttiattied ...concerned aboutti ttihe exttienttti offi ttihe abrasions ...reporttied tt(0ame) ttihatti residentti had been sttiripping offi clottihes.rolling on carpetti..we had repeattiedly putt back on his clottihing.reporttied ttihatti residentti had voiced...he was ittiching.doing a lotti offi scrattiching/picking atti areas." Att11:30 am, affier residentti ttiransffierred ttio psychiattiric hospittial...wiffie called.son going ttidhospittial nampe.. reporttied severe pain...were sedatting him..having a wound specialistti look atti him'</p> <p>An inttierview wittih Nurse, on 4/12/11 att1:34 pm, indicattied"...6:00 am ttie6:00 pm on 4/4/11- Monday...he was scrattiching and picking rash[sic] areas...asked 'Do you hurtti...he said 'I ittichedand he pointtied ttio ttihe rashy area...rash was dottis on chestti ffioirehead.above buttocks.. "</p> <p>The Unittti Manager was inttierviewed on</p>						

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	<p>4/12/11-1:5 5pm. She indicattied" ...was here Sunday (4/3) and Monday (4/4)...putti himselffi on carpetti while disrobed...crawled, scootti aroundlay on back and push across ffloor wittih his ffiçetti knees bentti on backlay and pull himselffi across carpetti on all ffiourshad carpetti burn on knees, you could ttiell itti was carpetti burnslattieral side off(L) leg, elbows and ffiotheadrib cage, bottih buttocks bottih ttighs, and back...were[sic] rash when you rubbed hand across rash areas, itti had ttiexttiure offi orange peel on ttihe rash areas.could ttiell ttihe diffierence bettiween ttihe rug burn areas and rash areas... "</p> <p>There were no orders or ttireattimenttis locattied in ttihe clinical recqrdr provided ffior an oral and/or ttioptical medicattion ttio address ttihe residentttitching There was no documenttiattion locattied or provided relattied ttio any conversattjowittih a Physician, which indicattied ttihe increased size and number offi skin injuries ttihe residentti had acquired during all ttihe conttiactti offi movementti across ttihe carpetti many ttimes wittih bare skin</p>						

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	<p>An observation offi Residentti was conducttied on 4/8/11 att 2:30 pm, att ttihe hospittial The residentti was sitting in his wheelchair, wearing a pair offi nylon shorttis, smiling and wattiching a couple offi pattienttis in ttihe small dining room. A sttiaffi member was also presentti She was in ttihe process offi removing ttihe residentti dressings ffirom his bilatttrial leg. There were large, very red, meattiy wounds on ttihe bilatttrial leg, ttihe worstti visible on ttihe leffi leg knee area, and calffi (medial, lattieral and ffiironttial area). The skin was sloughing offi (ayering down) and was lightti yellowish in color. The sttiaffi member indicattied ttihe wounds would be given air att ttihatti ttiime. The residentti was asked whatti had happened and he replied "I ttiink I was in a car wreck. She indicattied he was receiving wound care. She indicattied she had ttiaken care offi ttihe residentti prior ttio his discharge ttio ttihe Exttiended Care Facilittiy and he was no ttirouble att all ttio care ffiioffiactti he is real ffunny somettimes".</p> <p>The residentti was readmittied ttio ttihe hospittial on 4/05/11. Documenttiattion ffirom ttihe hospittial att 4/5/11 att 9:55 am, (received on 4/8/11 att 2:00 pm)</p>						

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	<p>indicattied...Upon arrival...was nottied.patientti had exttiensive abrasions wittih new scabbing Abrasions surrounded by redness, were warm...slighttily swollen.sensittive ttio ttiouch.called ffiacilittiDON and Administtirattior bottih identtified ttihattpatientti putti himselffi ffi oor...ttihey could notti resttirain him ttio preventti injury..." The hospittial provided a listti offi ttihe residentt abrasions, scabs, bruises, and all areas locattied on ttihe pattientti residentt's body, wittih measurementtisttihatti were new a/or larger since 4/01/11. There were 27 abrasions ranging ffirom1 cm ttio20 cm. They include ttihe ffiollowingputti notti all inclusive:</p> <p>1. L lattiera(outtside porttion) knee (20 cm lengttih and5 cm widttih)L lattieral knee (20 cm lengttih and8 cm widttih)L lattieral knee/leg (17 cm lengttih and8 cm widttih), L medial knee (10 cm diamettie, L medial knee (7 cm diamettie).</p> <p>2. R lattieral hip10 cm diamettie abrasion and L lattieral hip11 cm</p>						

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	<p>diametric abrasion.</p> <p>3. R lateral calf below knee cap 6 cm diametric, R medial knee cap (6 cm diametric, on R knee cap (5 cm diametric, R lateral knee cap 6 cm diametric, R medial below knee cap (3 cm diametric</p> <p>The nursing facility's Nursing Admission Assessment, dated 4/02/11 at 00:15 am, indicated a front and back body map The front side of body map had noted an abrasion on forehead a scratch on left upper chest, scab and abrasion on bilateral knees, scattered scratches on frontal bilateral calf, and a scratch on the outer portion of the right foot The back side of body map had bilateral red elbows with scratches and a scab and a red left heel</p> <p>The facility's Skin Impairment Assessment, dated 4/02/11, indicated the following abrasions occurred but were not present on admission. L outer knee (7.5 cm length and 4.0 cm width) and tender L outer lower leg 10.0 cm</p>						

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	<p>length and 3.5 cm width and tender (admitted scattered scratches anterior L leg, abrasion L knee-4.0 cm length with 4.0 cm width). "The second skin assessment documented 4/4/11, indicated the following skin issues occurred, but were not present upon admission. "R hip bruise (3.0 cm length and 3.0 cm width) and bilateral hip rash (general length) itching and red."</p> <p>This federal tag is related to complaint number IN00088970.</p> <p>3.1-37(a)</p>						

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F0329 SS=G	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview the facility failed to consider observable behaviors as symptoms as potential severe adverse reactions to a medication for residents reviewed for psychotropic drug use and untreated behaviors which resulted in restless and scratching/injurious behavior, multiple</p>			F0329	<p>Corrective Actions accomplished for those residents found to have been affected by the alleged deficient practice: Resident was re-admitted to Acute Psychiatric Hospital. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice therefore, through systemic changes stated below, will ensure</p>		05/12/2011

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	<p>abrasions, rug burns, and skin wounds.</p> <p>(Residentti) C</p> <p>Findings:</p> <p>A review offi Residentti'G clinical record was conducttied on 4/08/11 att4:00 pm. The record indicattied ttihe residentti had ttihe ffiollowing diagnosesbutti notti limittied ttio AnxiettiiDementtia wittih behavioral disttiurbancesSyncope, and hyperttension He admittied ttio ttihe ffiaciffittion an inpatientti psychiattiric hospitititit 4/01/11 att4:30 pm.</p> <p>A review offi ttihe hospitital discharge medicattion sheettittied 4/01/11 att1:44 pm, indicattied ttihe residentti was ttio receive ttihe ffiollowing medicattionsbutti notti all inclusive: Zyprexa Zydis (anttipsychottit 10 mg. (milligram) po (oral) q hs (each bedtttime),Attivan(anttianxiettii)0.5 mg po daily...Mottirinanttiiinffiammattioy analgesic) 800 mg. q6h prn...Ambien (insomnia) 10 mg. qhs prn..."</p> <p>The currentti Physician discharge orders ffior Residentti Were dattied as currentti</p>				<p>the Campus will provide a safe environment.Measures put into place and systemic changes made to ensure the alleged deficient practice does not recur:Licensed Nursing staff to be in-serviced on May 5, May 6, and May 9, 2011 on Change of Condition Guidelines (attachment 6), Change of Condition Form (attachment 7), Medication Administration General Guidelines (attachment 9), Preventing and Detecting Adverse Consequences (attachment 10), and Adverse Drug Reaction Report (attachment 11).Nursing Unit Manager will receive written disciplinary action on May 6, 2011 for administering medication without a physicians order.How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:Condition Changes and Adverse Reactions will be monitored daily by using the 24-hour nursing report and tracked weekly in the Clinically at Risk (CAR) meeting per the interdisciplinary team until resolved. Results will be reviewed monthly at QA Committee meetings.</p>		

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	<p>4/01/11 attl:44 pm and ffixated aai19 pm. The orders indicattied ttihe residentti had admittied ttio ttihe hospittial3/18/11 wittih a diagnosis offi Syncopffiaintting or loss offi consciousness. The ffiollowing discharge orders indicattied...ttihe ffiollowing psych meds should be continued..please see MAR (medicattion administrattion reco)dfior ottiher medicattions.." The nottied2 meds were "1. Attivan0.5 mg. (milligram) PO (by mouttih)daily, 2Zyrex Zydis 10 mg PO daily @ HS (bedtttime)..." The MAR indicattied ttihe Zyprexa Zyd10 mg) was sttiarttied 3/28/11 and nottied ttihe ffiollowing ordersbutti are notti all inclusive: "...Attivan0.5 mg po q4h prn ttio be continued..Attivan0.5 mg po QD routine ttio be continued"</p> <p>The Discharge Summary, indicattied ttihe residentti had admittied ttio ttihe hospittial on 3/18/11, ttio ttihe Inttensive Care Unitti relattied ttisyncopal attiacks atti homle began displaying spells offi agittiatation and observed ttio be very anxiousrresttleess agittiatiedonffiusedand poor judgementti so was ttitransffierred ttio ttihe Psychiattiric ffioor</p>						

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	<p>offi tthe hospitlResidentti C was sttiarttied on Zyprexa Zydys 2.5 mg. BID (ttiwiice daily), dose was gradually increased tti6 mg atti bedttimethe pattiientti was given Attivan0.5 mg BID ffior severe anxiettti and his Zyprexa Zydys was increased tti10 mg on 3/28/11 and ttihe medicattions were documentttiedin ttihe summaryttio be continued atti ttihe nursing ffiacilittiy</p> <p>On 4/11/11 ttihe 'WebsittieDrugs.com' was reviewed ffior ttihe side effiecttis offi Zyprexa Zydys (anttipsychottic medicattio) ' "The 'Zyprexa Zydys Side Effiecttis indicattied" ...Seek medical attienttion rightti away iffi any offi ttihe SEVERE side effiecttis occur when using Zyprexa Zydys Orally Disinttiegratting Tablettsevere allergic reacttions(rash,, hives, ittching..ttirouble sitting sttillttirouble walking or sttianding..Dermattilogic side effiecttisffirequenttily include ecchymosis (bruising)...pruittiusitticha ttingling or ffainttily burning skin sensattion ttihatti prompttis a person ttio rub or scratch ...skin ulcer ...Hypersensittivittiygeneralized prurittic skin erupttion..reporttied case pattiientti</p>						

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	<p>presenttied wittih severe generalized prurittic skin erupttion 60 days affier ingesttion offi olanzapin(Zyprexa) ... "</p> <p>"The Nursing Specttirum Drug Handbook-2010" indicattied Zyprexa...'Adverse Reaction's...resttlessness.insomnia...agittia ttion... "</p> <p>C.N.A. #2 was inttierviewed on 4/12/11 atti 2:22 pm. She indicattied' ...work on weekend on Sattiurday 4/02...he was handfful. Couldrtti keep in bed.keptti ttiaking clottihes offimpossible ttio keep him in bed on mattis.Tried ttio give ttihe bestti care we could..ffamily ttihere and agreed ffor him ttio be on ffiadffamily requestttied he had med ttio calm him some...didn'tti sleep sttillHe'd have his clottihes offi in 5 minutties affier ttihey were putti on him.would wiggle on matti.did getti rug burns ffirom being on carpette done [sic] itti ttio himselffi</p> <p>An inttierviewwon 4/12/11 att8:25 pm, wittih C.N.A. #1indicattied she had worked ffiron 6am ttio 6 pm on 4/01/11, ttihe day offi Residentti 6 admission. They indicattied"</p>						

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	<p>...impossible ttiio getti him ttiio sittt. still a serious case offi ttihe wiggleshe would snake, slittiher'somettimes on matti somettimes on rug Always scrattching and picking on skin... " C.N.A. #3, inttierviewed attt 06 pm on 4/12/11, indicattied ttihey had worked nighttis on Satttiurday (4/2) and Sunday (4/3)...was on ttihe fffloor wittih docttior. Keptti sttirripping.would slide on ttihe carpetti (wittihoutti) clotttiies Sunday nightti.ffiound a onesie wittih a sweattier.borrowed itti and putti itti.ottti was on sttill slid around on fffloor butti his skin was covered...also...ttiiook offi elbow and knee pads...had rug burns on legs, arm, area, chestti and ffioreheatthinks ttihey were rug burns.didn'tti crawl.whole body would slide across carpetti.had putti 1 matti on fffioarhe...ffiolded itti and pushed itti outti offi ttihe.wayer ttihe weekend.. "</p> <p>Nurse #2, inttierviewed on 4/12/11 attt 2:44 pm, indicattied" ...he couldn'tti walk.keptti ttirying ttiio getti up his alarms keptti going offi attt 3:00 am...conttirolled ffiialhelped him ttiio ttihe ffiioarnded getting rug burn ffirom crawling around on fffloor..wanttiied ttiio</p>						

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	<p>sttiay. area on knee was red ffirom ffiall.happened on ...ffloor wittihin 10 minutties.wanttied ttio getti him up and notti letti him crawl look whatti happeneddid 1:1...restti offi shiffid incidenttti reportti on skin... "</p> <p>An Incidentti Reportttattied4/02/11 atti 02:45 am, was provided by ttihe ffiacilittiy on 4/12/11. The reportti indicattie'd ...wittinessed.res (residentti)..up walking around bed atttemptting ttio ttiurn offi alarm...writtier assistti res ttio ffiore declined ttio getti up offi ffioreceived abrasion ttio ((leffi) knee and L outtier leg...assisttied ffiialselffi inffiicttied injury-wittinessed... "</p> <p>A review off2 documenttis,dattied4/2/11, ttittiled Ottiher Skin Impairmentti Assessmentttf indicattied ttihe residentti had abrasions which were notti presentti upon admission ttio ttihe ffiacilityThe leffi outtier knee had a lengttih off5 cm by a widdtih offi 4.0 cm and was nottied ttio be ttiendThe leffi outtier lower leg had an abrasion wittih a lengttih off0.0 cm by 3.5 cm widdtih and also nottied ttio be ttiendThere were 2</p>						

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	<p>addittional skin assessmenttied 4/2/11, which indicattied abrasions ttio ttihe kneeswhich were observed on admission. The leffi knee had a lengtth offi 4.0 cm by 4.0 cm and ttihe rightti knee had lengtth offi 2 cm by 3.0 cm. widthti.</p> <p>A physician ' s progress nottiedattied 4/2/11, indicattied" ...Exam atti tthis ttime reveals a large male residentti resting on ttihe ffloor...skinis.remarkable in ttihatti he has some superfficial abrasions or bruises on...ffioreheadscattered on..arms and bottih ...legs .would appear ttio beone would guess, ffirom his behavior offi getting up and down ffirom.chair, up and down ffirom.bed, and scootting around on ttihe ffloor..ttihink we should consider eittiher Risperdal or atti tthis pointti increasing his Zyprexa ttio atti leaSting. in ttihe morning and continue ttihe 10 mg. atti nightti"</p> <p>A " Change in Condittion Form", dattied 4/3/11 attt11:50 am, indicattied" ...Family atti bedside.sttiattied res was receiving Attivan Qh routine attthospittial name)...sttiattie res seems ttio be worse since med was decreased...requestting</p>						

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	<p>change...1. Attivan qh routine Alzheimer's wittih behaviors. "</p> <p>The nursing nottiesdattied4/04/11 att3:00 pm, indicattied ttihe wiffie and niece visittied ttihe ffiacilittlyWiffie nottiffiedresidentti remains resttless.non-redirectti able crawling on ffloor; removing clottihes.rolling up matti on ffloor..inffirmed offi saffiettiy concerns because residentti.repeattiedly removing clottihes.scootting across carpetti causing abrasions ttihroughouttturrenttily has abrasions on chestttisttiomachback, buttiocls in addittion ttio abrasions he came wittih.also scrattiching attipicking ...abrasions ...scabs ...niece researched Zyprexa and ttihose are side effecttiswiffie requesttis we sttiop Zyprexainffirmed ...sttiaffi.place 2 mattires[sic], ttihree mattis ...numerous blankettis on ffloor ttio keep residentti ffirom causing ffiurttiher injury ttio selffi ... " The nurse indicattied ttihatti ttihe residentti would roll up ttihe matttiack ttihem and ttihen roll on ttihe ffiore notties on4/4/11 att5 pm, indicattied" res has multtiple rash areas etti res nottied ttio be picking atti skinttiaring in several places..</p>						

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	<p>"</p> <p>The nursing nannies dated 4/5/11 at 10:30 am, indicated that the accepting hospital had contacted the facility and stated ...concerned about the extent of the abrasions ...reported that (name) that the resident had been stripping off clothes ...rolling on carpet. we had repeatedly put back on his clothing reported that the resident had voiced..he was itching ...doing a lot of scratching/picking at areas ... " At 11:30 am, " ...wife called ...requested how resident was previous night..informed her that per report the resident had been restless demanding to be on floor, stripping off clothing. The wife indicated that son was going to (hospital name)...had reported severe pain ...were sedating him...having a wound specialist look at him. The nannies on 4/5/11 at 11:55 am, indicated " ...did report that (name) family [sic] concern about possible reaction to Zyprexa ...that the resident had been restless throughout the night repeatedly stripping off clothes scratching himself "</p>						

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	<p>An inttierview wittih Nurse on 4/12/11 attt 1:34 pm, indicattied" ...ffirsttti ttiimeatttiaking care offi him..was working 6:00 am ttio 6:00 pm on 4/4- Monday ...pretttiy ffirequenttily had someone in room ...C.N.As ttiook ttiurnshe was scratttiching and picking rashy [sic] areas ...asked 'Do you hurttt...he said 'I ittiched(sic) and he pointttied ttio ttihe rashy areaash was dotttis on chestttiffiorehead..above buttocks.." "</p> <p>The Unitti Manager was inttierviewed on 4/12/11 attt1:55 pm. She indicattied her name was " ...nottti on sttiaffing sheetttwas here Sunday (4/3) and Monday (4/4)...putti himselffi on carpetti while disrobed...crawled, scoottt(sic) around, lay on back and push across ffloor wittih his fffeettti knees bentti on backlay and pull himselffi across carpetti on all ffiouuttad carpetti burn on kneesyou could ttiell itti was carpetti burnslattieral side off(L) leg, elbows and ffioreheadrib cage, bottti buttiocckss bottti ttiighs, and back...were[sic] rash when you rubbed hand across rash areas, itti had ttiextttiure offi orange peel on ttihe rash areas.could ttiell</p>						

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	<p>the difference between the rug burn areas and rash areas...he kept picking at the forehead. scratch front cheeks...She asked 'Does it hurt?' he replied 'Bad'...was very adamant." The Unit Manager indicated the staff probably had used hydrocortisone cream on the resident as the facility had a standing order for the cream until the physician could be reached for a different treatment.</p> <p>The Clinical Nurse (DCS) was interviewed on 4/12/11 at 3:55 pm. She indicated the facility did not have any standing orders for hydrocortisone cream (for itching and/or inflammation) or lidex cream, so the creams would not have been used on the resident.</p> <p>There were no physician's orders located or provided which would have indicated the resident's itching had been addressed. There were no orders or treatment located in the clinical record or provided for an oral and/or topical medication to address the resident's itching.</p>						

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	<p>An phone interview was conducted, on 4/21/11 at 10:30 am, to reconfirm Resident C's psychotropic medication regime with his readmission to the hospital. His medications had been changed to Seroquel 100 mg. Q HS, Seroquel 50 mg BID at 8 am and 1 pm, Depakote 500 mg. BID, Depakote 250 mg at 1:00 pm, Klonopin 0.5 mg TID (3 times daily) and Benedryl Q 4H, prn (for itching). He was no longer taking Zyprexa Zydis.</p> <p>A review of the hospital nursing notes indicated " addendum: 4/05/11 at 10:01 pm, Pti describes pain as throbbing but not too bad 4/6/11 at 2:14 am, "No agitation or aggression noted. Pti confused but cooperative with all care...easily redirected to allow assistance with all transfers. Pti in bed at this time with bed alarm, straps locked, bed in low position, non-skid footwear only attempted to get out of bed on own 1 time..." 4/6/11 at 9:00 am, "all wounds still red and weepy...cleansed...ointment applied per orders..." 4/6/11 at 4:25 pm, "Pti has</p>						

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	<p>shown no S/S (signs and symptoms) of aggression nor aggression today is restless when out of bed however, cooperative with staff 4/7/11 at 2:10 am, "No aggression or aggression noticed 4/7/11 at 11:19 am, "Patient is confused but cooperative with all care 4/7/11 at 11:19 am, "Patient has poison ivy and...itching benedryl ordered..." 4/7/11 at 8:28 pm, " Patient has shown no S/S of aggression nor aggression today He is calm and cooperative.." 4/08/11 at 8:00 am, "Patient has been cooperative with care and took his pm meds crushed w/o (with out) difficulty. started off sitting in w/c with chair alarm set transporting self via w/c (with out) difficulty</p> <p>This federal tag is related to complaint number IN00088970</p> <p>3.1-48(a)(3) 3.1-48(a)(5) 3.1-48(a)(6)</p>						

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